Mental Illness is Still a Myth

by Thomas Szasz

Thomas Szasz is Professor Emeritus of Psychiatry at the State University of New York in Syracuse, New York. He is author of *The Myth of Mental Illness*. His most recent book is *Cruel Compassion: Psychiatric Control of Society's Unwanted*.

Society (31:4, pages 34-39)

In a memorable statement C. S. Lewis once remarked, "Of all the tyrannies a tyranny sincerely exercised for the good of its victims may be the most oppressive.... To be 'cured' against one's will and cured of states which we may not regard as disease is to be put on a level with those who have not yet reached the age of reason or those who never will; to be classed with infants, imbeciles, and domestic animals." These words still apply to psychiatry today.

Anyone with an ear for language will recognize that the boundary that separates the serious vocabulary of psychiatry from the ludicrous lexicon of psychobabble, and both from playful slang, is thin and permeable to fashion. This is precisely wherein lies the richness and power of language that is inexorably metaphoric. Should a person want to say something sensitive tactfully, he can, as the adage suggests, say it in jest, but mean it in earnest. Bureaucrats, lawyers, politicians, quacks, and the assorted mountebanks of the "hindering professions" are in the habit of saying everything in earnest. If we want to protect ourselves from them, we had better hear what they tell us in jest, lest the joke be on us.

As far back as I can remember thinking about such things, I have been struck by the analogic-metaphoric character of the vocabulary of psychiatry, which is nevertheless accepted as a legitimate medical idiom. When I decided to discontinue my residency training in internal medicine and switch to psychiatry, I did so with the aim of exploring the nature and function of psychiatry's metaphors and to expose them to public scrutiny as

figures of speech.

During the 1950s, I published a score of articles in professional journals, challenging the epistemological foundations of the concept of the mental illness and the moral basis of involuntary mental hospitalization. In 1958, as my book, *The Myth of Mental Illness,* was nearing completion, I wrote a short paper of the same title and submitted it to every major American psychiatric journal. Not one of them would accept it for publication. As fate would have it—and because the competition between psychologists and psychiatrists for a slice of the mental health pie was then even more intense than now—*The American Psychologist* published the essay in 1960. The following year the book appeared. I think it is fair to say that psychiatry has not been the same since.

Responses to my work have varied from lavish praise to bitter denunciation. American psychiatrists quickly closed ranks against me. Official psychiatry simply dismissed my contention that (mis)behaviors are not diseases and asserted that I "deny the reality that mental diseases are like other diseases," and distorted my critique of psychiatric slavery as my "denying life-saving treatment to mental patients." Actually, I have ought to deprive psychiatrists of their power to involuntarily hospitalize or treat competent adults called "mental patients." My critics have chosen to interpret this proposal as my trying to deprive competent adults of their right or opportunity to seek or receive psychiatric help. By 1970, I had become a nonperson in American psychiatry. The pages of American psychiatric journals were shut to my work. Soon, the very mention of my name became taboo and was omitted from new editions of texts that had previously featured my views. In short, I became the object of that most effective of all criticisms, the silent treatment —or, as the Germans so aptly call it, *Totschweigetaktik*.

In Great Britain, my views elicited a more favorable reception. Some English psychiatrists conceded that not all psychiatric diagnoses designate *bona fide* diseases. Others were sympathetic to the plight of persons in psychiatric custody. Regrettably, that posture rested heavily on the misguided patriotic belief that the practice of psychiatric slavery was less common in England than in the United States.

Not surprisingly, my work was received more favorably by philosophers, psychologists, sociologists, and civil libertarians, who recognized the merit of my cognitive challenge to the concept of mental illness, and the legitimacy of my questioning the morality of involuntary psychiatric interventions. I thus managed to set in motion a controversy about mental
illness that is still raging.

When people now hear the term “mental illness,” virtually everyone acts as if he were unaware of the distinction between literal and metaphoric uses of the word “illness.” That is why people believe that finding brain lesions in some mental patients (for example, schizophrenics) would prove, or has already proven, that mental illnesses exist and are “like other illnesses.” This is an error. If mental illnesses are diseases of the central nervous system (for example, paresis), then they are diseases of the brain, not the mind; and if they are the names of (mis)behaviors (for example, using illegal drugs), then they are not diseases. A screwdriver may be a drink or an implement. No amount of research on orange juice and vodka can establish that it is a hitherto unrecognized form of a carpenter’s tool.

Such linguistic clarification is useful for persons who want to think clearly, regardless of consequence. However, it is not useful for persons who want to respect social institutions that rest on the literal uses of a master metaphor. In short, psychiatric metaphors play the same role in therapeutic societies as religious metaphors play in theological societies. Consider the similarities. Mohammedans believe that God wants them to worship on Friday, Jews that He wants them to worship on Saturday, and Christians that He wants them to worship on Sunday. The various versions of the American Psychiatric Association’s (APA) *Diagnostic and Statistical Manual* rest on the same sort of consensus. How does behavior become illness? By the membership of the American Psychiatric Association reaching a consensus that, say, gambling is an illness and then issuing a declaration to that effect. Thereafter “pathological gambling” is a disease.

Obviously, belief in the reality of a psychiatric fiction, such as mental illness, cannot be dispelled by logical argument any more than belief in the reality of a religious fiction, such as life after death, can be. That is because, *inter alia*, religion is the denial of

the human foundations of meaning and of the finitude of life; this authenticated denial lets those who yearn for a theo-mythological foundation of meaning and who reject the reality of death to theologize life and entrust its management to clerical professionals. Similarly, psychiatry is the denial of the reality of free will and of the tragic nature of life; this authenticated denial lets those who seek a neuro-mythological explanation of human wickedness and who reject the inevitability of personal responsibility to medicalize life and entrust its management to health professionals. Marx was close to the mark when he asserted that religion was "the opiate of the people." But religion is not the opiate of the people. The human mind is. For both religion and psychiatry are the products of our own minds. Hence, the mind is its own opiate; and its ultimate drug is the word.

Freud himself flirted with such a formulation. But he shied away from its implications, choosing instead to believe that "neuroses" are literal diseases, and that "psychoanalysis" is a literal treatment. As he wrote in his essay "Psychical (or Mental) Treatment":

> *Foremost among such measures [which operate upon the human mind] is the use of words; and words are the essential tool of mental treatment. A layman will no doubt find it hard to understand how pathological disorders of the body and mind can be eliminated by 'mere' words. He will feel that he is being asked to believe in magic. And he will not be so very wrong.... But we shall have to follow a roundabout path in order to explain how science sets about restoring to words a part at least of their former magical power.*

I took up the profession of psychiatry in part to combat the contention that abnormal behaviors are the products of abnormal brains. Ironically, it was easier to do this fifty years ago than today. In the 1940s, the idea that every phenomenon named a "mental illness" will prove to be a *bona fide* brain disease was considered to be only a hypothesis, the validity of which one could doubt and still be regarded as reasonable. Since the 1960s, however, the view that mental diseases are diseases of the brain has become scientific fact. This contention is the bedrock claim of the National Alliance for the Mentally Ill (NAMI), an organization of and for the relatives of mental patients, with a membership in excess of one

hundred thousand. Its “public service” slogan, intoned like a mantra, is: “Learn to recognize the symptoms of Mental Illness. Schizophrenia, Manic Depression, and Severe Depression are Brain Diseases.”

Psychiatrists and their powerful allies have thus succeeded in persuading the scientific community, the courts, the media, and the general public that the conditions they call “mental disorders” are diseases—that is, phenomena independent of human motivation or will. This development is at once curious and sinister. Until recently, only psychiatrists—who know little about medicine and less about science—embraced such blind physical reductionism.

Most scientists knew better. For example, Michael Polanyi, who made important contributions to both physical chemistry and social philosophy, observed: “The recognition of certain basic impossibilities has laid the foundations of some major principles of physics and chemistry; similarly, recognition of the impossibility of understanding living things in terms of physics and chemistry, far from setting limits to our understanding of life, will guide it in the right direction.”

It is no accident that the more firmly psychiatrically-inspired ideas take hold of the collective American mind, the more foolishness and injustice they generate. The specifications of the Americans With Disabilities Act (AWDA), a federal law enacted in 1990, is a case in point.

Long ago, American lawmakers allowed psychiatrists to literalize the metaphor of mental illness. Having accepted fictitious mental diseases as facts, politicians could not avoid specifying which of these manufactured maladies were covered, and which were not covered, under the AWDA. They had no trouble doing so, creating a veritable “DSM-Congress,” that is, a list of mental diseases accredited by a congressional, rather than a psychiatric, consensus group. Thus, the AWDA covers “claustrophobia, personality problems, and mental retardation, [but does not cover] kleptomania, pyromania, compulsive gambling, and...transvestism.” It is reassuring to know that the Congress of the United States agrees with me that stealing, setting fires, gambling, and cross-dressing are not diseases.

Thus, the various versions of the APA's *Diagnostic and Statistical Manual of Mental Disorders* are not classifications of mental disorders that "patients have," but are rosters of officially accredited psychiatric diagnoses. This is why in psychiatry, unlike in the rest of medicine, members of "consensus groups" and "task forces," appointed by officers of the APA, make and unmake diagnoses, the membership sometimes voting on whether a controversial diagnosis is or is not a disease.

For more than a century, psychiatrists constructed diagnoses, pretended that they are diseases, and no one in authority challenged their deceptions. The result is that few people now realize that diagnoses are not diseases. Diseases are demonstrable anatomical or physiological lesions, that may occur naturally or be caused by human agents. Although diseases may not be recognized or understood, they "exist." People have hypertension and malaria, regardless of whether or not they know it or physicians diagnose it.

Diagnoses are disease names. Because diagnoses are social constructs, they vary from time to time, and from culture to culture. Focal infections, masturbatory insanity, and homosexuality were diagnoses in the past; now they are considered to be diagnostic errors or normal behaviors. In France, physicians diagnose "liver crises"; in Germany, "low blood pressure"; in the United States, "nicotine dependence."

These considerations raise the question: Why do we make diagnoses? There are several reasons: (1) Scientific —to identify the organs or tissues affected and perhaps the cause of the illness; (2) Professional—to enlarge the scope, and thus the power and prestige, of a state-protected medical monopoly and the income of its practitioners; (3) Legal—to justify state-sanctioned coercive interventions outside of the criminal justice system; (4) Political-economic—to justify enacting and enforcing measures aimed at promoting public health and providing funds for research and treatment on projects classified as medical; (5) Personal—to enlist the support of public opinion, the media, and the legal system for bestowing special privileges (and impose special hardships) on persons diagnosed as (mentally) ill.

It is no coincidence that most psychiatric diagnoses are twentieth-century inventions. The aim of this classic, nineteenth-century model of diagnosis was to identify bodily lesions (diseases) and their material causes (etiology). The term “pneumococcal pneumonia,” for example, identifies the organ affected, the lungs, and the cause of the illness, infection with the pneumococcus. Pneumococcal pneumonia is an example of a pathology-driven diagnosis.

Diagnoses driven by other motives—such as the desire to coerce the patient or to secure government funding for the treatment of the illness—generate different diagnostic constructions and lead to different conceptions of disease. Today, even diagnoses of (what used to be) strictly medical diseases are no longer principally pathology-driven. Because of thirdparty funding of hospital costs and physicians’ fees, even the diagnoses of persons suffering from *bona fide* illnesses—for example, asthma or arthritis—are distorted by economic considerations. Final diagnoses on the discharge summaries of hospitalized patients are often no longer made by physicians, but by bureaucrats skilled in the ways of Medicare, Medicaid, and private health insurance reimbursement—based partly on what ails the patient, and partly on which medical terms for his ailment and treatment ensure the most generous reimbursement for the services rendered.

As for psychiatry, it ought to be clear that, except for the diagnoses of neurological diseases (treated by neurologists), no psychiatric diagnosis is, or can be, pathology-driven. Instead, all such diagnoses are driven by non-medical, that is economic, personal, legal, political, or social considerations and incentives. Hence, psychiatric diagnoses point neither to anatomical or physiological lesions, nor to disease-causative agents, but allude to human behaviors and human problems. These problems include not only the plight of the denominated patient, but also the dilemmas with which the patient, relatives, and the psychiatrist must cope and which each tries to exploit.

My critique of psychiatry is two-pronged, partly conceptual, partly moral and political. At the core of my conceptual critique lies the distinction between the literal and metaphorical use of language—with mental illness as a metaphor. At the core of my moralpolitical critique lies the distinction between relating to grown persons as

responsible adults and as irresponsible insane persons (quasi-infants or idiots)—the former possessing free will, the latter lacking this moral attribute because of being "possessed" by mental illness. Instead of addressing these issues, my critics have concentrated on analyzing my motives and defending psychiatric slavery as benefiting the "slaves" and society alike. The reason for this impasse is that psychiatrists regard their own claims as the truths of medical science, and the claims of mental patients as the manifestations of mental diseases; whereas I regard both sets of claims as unwarranted justifications for imposing the claimants' beliefs and behavior on others. Because the secret to unraveling many of the mysteries of psychiatry lies in distinguishing claims from assertions, descriptions, suggestions, or hypotheses, let us briefly examine this concept.

Advancing a claim means seeking, by virtue of authority or right, the recognition of a demand—say, the validity of an assertion (in religion), or entitlement to money damages (in tort litigation). To use my previous example, Muslims, Jews, and Christians all claim that God created the world in six days and on the seventh He rested. However, each faith names a different day of the week as the day of rest. Similarly, (some so-called) psychotics assert that they hear voices that command them to kill their wives or children; psychiatrists assert that such persons suffer from a brain disease called "schizophrenia," which can be effectively treated with certain chemicals; and I claim that the assertions of psychotics and psychiatrists alike are claims unsubstantiated by evidence. The point, however, is that psychiatrists have the power to accredit their own claims as scientific facts and rational treatments, discredit the claims of mental patients and psychiatric critics as delusions and denials, and enlist the coercive power of the state to impose their views on involuntary "patients."

The difference between a description and a claim is sometimes a matter of context rather than vocabulary. For example, the adjective "schizophrenic" may describe a man who asserts that his wife is trying to poison him (assuming that she is not); but it functions as a claim when, after shooting his wife, the killers' court-appointed lawyer, desperate to "defend" him (perhaps against his nominal client's wishes), claims that the illegal act was caused by schizophrenia and that the killer should therefore be "acquitted" and treated in a mental hospital, rather than punished by

imprisonment. Because psychiatrists view mental diseases and their treatments as facts rather than as claims, they reject the possibility that the words “illness” and “treatment” may, as all words, have a literal or metaphorical usage. Although some psychiatrists now concede that hysteria is not a genuine disease, they are loath to acknowledge that it is a metaphorical disease, that is, not a disease at all. Similarly, many psychiatrists acknowledge that psychotherapy—that is, two or more persons listening and talking to one another—is radically unlike surgical and medical treatment. But, again, they do not acknowledge that it is a metaphorical treatment—that is, not a treatment at all.

Finally, psychiatrists, who potentially always deal with involuntary patients, delight in the doubly selfserving claim that their patients suffer from brain diseases and that these (psychiatric) brain diseases (unlike others, such as Parkinsonism) render their sufferers incompetent. This claim lets psychiatrists pretend that coercion is a necessary, yet insignificant, element in contemporary psychiatric practice, a claim daily contradicted by reports in the newspapers. Understandably, psychiatrists prefer to occupy themselves with the putative brain diseases of persons called “mental patients” than with the proven social functions of psychiatric diagnoses, hospitals, and treatments.

Lawmakers do not discover prohibited rules of conduct, called crimes, they create them. Killing is not a crime; only unlawful killing is—for example, murder. Similarly, psychiatrists do not discover (mis)behaviors, called mental diseases, they create them. Killing is not a mental disease; only killing defined as due to mental illness is; schizophrenia thus “causes” hetero-homicide (not called “murder”) and bipolar illness “causes” auto-homicide (called “suicide”).

My point is that psychiatrists, who create diagnoses of mental diseases by giving disease names to personal (mis)conduct, function as legislators, not as scientists. It was this sort of diagnosis-making alienists engaged in when they created masturbatory insanity; that Paul Eugen Bleuler engaged in when he created schizophrenia; and that the task force committees of the American Psychiatric Association engage in when they construct new psychiatric diagnoses, such as body dysmorphic disorder, and deconstruct old ones, such as homosexuality.

I am not arguing that rule making, such as politicians engage in, is not important. I am merely insisting on the differences between phenomena and rules, science and law, cure and control. Treating the sick and punishing criminals are both necessary for maintaining the social order. Indeed, breakdown in the just enforcement of just laws is far more destructive to the social order than the absence of equitable access to effective medical treatment. The medical profession's traditional social mandate is healing the sick; the criminal justice system's, punishing the lawbreaker; and the psychiatric profession's, confining and controlling the "deviant" (ostensibly as diseased, supposedly for the purpose of treatment). This is why I regard psychiatry as a branch of the law and a secular religion, rather than a science or therapy.

I want to add a brief remark here on the so-called anti-psychiatry movement with which my name is often associated. As detailed elsewhere, I consider the term anti-psychiatry imprudent and the movement it names irresponsible. As a classical liberal, I support the rights of physicians to engage in mutually consenting psychiatric acts with other adults. By the same token, I object to involuntary psychiatric interventions, regardless of how they are justified. Psychiatrists *qua* physicians should never deprive individuals of their lives, liberties, and properties, even if the security of society requires that they engage in such acts. In adopting this view, I follow the example of the great Hungarian physician Ignaz Semmelweis who believed that obstetricians, *qua* physicians, should never infect their patients, even if the advancement of medical education requires that they do so.

I do not deny that involuntary psychiatric interventions might be justified *vis—vis* individuals declared to be legally incompetent, just as involuntary financial or medical interventions are justified under such circumstances. Individuals who are disabled by a stroke or are in a coma cannot discharge their duties or represent their desires. Accordingly, there are procedures for relieving them—with due process of law—of their rights and responsibilities as fullfledged adults. Although the persons entrusted with the task of reclassifying citizens from moral agents to wards of the state might make use of medical information, they should be lay persons (jurors) and judges, not physicians or mental health specialists.

Their determination should be viewed as a legal and political procedure, not as a medical or therapeutic intervention.

I have sought to alert the professions as well as the public to the tendency in modern societies—whether capitalist or communist, democratic, or totalitarian— to reclassify deviant conduct as (mental) disease, deviant actor as (psychiatric) patient, and activities aimed at controlling deviants as therapeutic interventions. And I have warned against the dangers of the destruction of self-discipline and criminal sanctions which these practices create—specifically the replacing of penal sanctions with psychiatric coercions rationalized as "hospitalization" and "treatment." To describe the confusion arising from the use of the metaphorical term "mental disease," I have suggested the phrase "the myth of mental illness." For a political order that uses physicians and hospitals in place of policemen and prisons to coerce and confine miscreants and which justifies constraint and compulsion as therapy rather than punishment, I have proposed the name "therapeutic state."

The personal freedom of which the English and American people are justly proud rests on the assumption of a fundamental right to life, liberty, and property. This is why deprivations of life, liberty, and property have traditionally been regarded as punishments (execution, imprisonment, and the imposition of a fine), that is, legal and political acts whose lawful performance is delegated to specific agents of the state and is regulated by due process of law. No physician *qua* medical healer has the right to deprive another of life, liberty, or property. Formerly, when the clergy was allied with the state, a priest had the right to deprive a person of life and liberty. In the seventeenth century, the state began to transfer this role to psychiatrists (alienists or mad-doctors), who eagerly accepted the assignment and have served as state agents authorized to deprive persons of liberty under medical auspices. Now, we are witnessing a clamor for granting physicians the right to kill persons—an ostensibly medical intervention euphemized as "physician-assisted suicide."

It is a truism that the interests of the individual, the family, and the state often conflict. Medicalizing interpersonal conflicts, that is, disagreements among family members, the members of society, and between citizens and the state, threatens to destroy not only

respect for persons as responsible moral agents, but also for the state as an arbiter and dispenser of justice. Let us never forget that the state is an organ of coercion with a monopoly on force—for good or ill. The more the state empowers doctors, the more physicians will strengthen the state (by authenticating political preferences as health values), and the more the resulting union of medicine and the state will enfeeble the individual (by depriving him of the right to reject interventions classified as therapeutic). If that is the kind of society we want, that is the kind we shall get—and deserve.